Note: System of Care Services are voluntary for the family

CT System of Care Uniform Client Record: I. REFERRAL FORM/FACE SHEET

Child/Youth's Name:			
D.O.B.:	**Age:**	**Gender: Male [ ] Female [ ]**	
Community Collaborative/System of Care:			
Was EMPS # Provided: Yes [ ] No [ ]	**Date of Referral:**		

Referral Source Name:		**Phone Number:**	
Referral Source Code (please check a source code below):			
[ ] (1) Danbury DCF	[ ] (14) National Runaway Hotline	[ ] (27) Residential Facility	[ ] (44) Employee Assistance Program
[ ] (2) Torrington DCF	[ ] (15) Crisis Intervention Hotline	[ ] (28) Police	[ ] (45) Juvenile Court, Probation or Parole
[ ] (3) Waterbury DCF	[ ] (16) Child Guidance Clinic	[ ] (29) Hospital	[ ] (46) Family Advocate
[ ] (4) Manchester DCF	[ ] (17) Court/Public Defender/Atty.	[ ] (30) Friend	[ ] (47) Extended Day Treatment
[ ] (5) New Britain DCF	[ ] (18) Youth Service Bureau	[ ] (31) School	[ ] (48) Emergency Psych. Treatment
[ ] (6) Middletown DCF	[ ] (19) Social Service Agency	[ ] (32) Norwalk DCF	[ ] (49) Intensive Family Preservation
[ ] (7) Norwich DCF	[ ] (20) Clergy	[ ] (33) Hartford DCF	[ ] (50) Parent Aide
[ ] (8) Meriden DCF	[ ] (21) Self	[ ] (34) Physician	[ ] (51) Partial Hospitalization
[ ] (9) New Haven DCF	[ ] (22) Parent	[ ] (35) Willimantic DCF	[ ] (52) Dept. of Social Services
[ ] (10) Bridgeport DCF	[ ] (23) Info-Line	[ ] (37) Relative	[ ] (53) Dept. of Mental Retardation
[ ] (11) Stamford DCF	[ ] (24) Foster Family	[ ] (41) Substance Abuse Agency	[ ] (54) Private Provider
[ ] (12) Hotline DCF	[ ] (25) Group Home	[ ] (42) Local Systems of Care	[ ] (62) Emergency Room
[ ] (13) DCF Unspecified	[ ] (26) Temporary Shelter	[ ] (43) Insurance – HMO	[ ] (63) Department of Corrections
			[ ] (99) Other

Hispanic: Yes [ ] No [ ]		
Child's Ethnicity (Please check applicable box):		
[ ] (5) Central American	[ ] (12) Korean	[ ] (20) Mexican
[ ] (6) South American	[ ] (13) Laotian	[ ] (21) Cuban
[ ] (7) Other Spanish Speaking	[ ] (14) Thai	[ ] (22) African American
[ ] (8) West Indies/Islander	[ ] (15) Vietnamese	[ ] (23) Portugese
[ ] (9) Cambodian	[ ] (16) Asian Indian	[ ] (24) Dominican
[ ] (10) Chinese	[ ] (18) Bi-Racial	[ ] (99) Other (Please specify)
[ ] (11) Japanese	[ ] (19) Puerto Rican	
Child's Race (Please check applicable box):		
[ ] (1) White	[ ] (3) Asian American	[ ] (23) Pacific Islander
[ ] (2) Black	[ ] (22) Native American	

Child/Youth's Residing Address:

Child's Current Living Arrangement (Please check applicable box):	
[ ] (0) Unknown	[ ] (10) Residential Treatment Facility (Other than DCF Operated)
[ ] (1) With either or both parents	[ ] (11) Hospital in the Community, Psychiatric Unit
[ ] (2) With relative other than parent	[ ] (12) Hospital in the Community, Medical Bed
[ ] (3) Foster home (in the community)	[ ] (13) Psychiatric Hospital
[ ] (4) Foster home (out of the community)	[ ] (14) DCF Residential Treatment
[ ] (5) With friend or family friend	[ ] (15) DCF Psychiatric Hospital (Riverview)
[ ] (6) Emergency shelter for children	[ ] (20) Crisis Stabilization Bed
[ ] (7) Family homeless shelter	[ ] (98) Homeless
[ ] (8) Safe Home/Host Home	[ ] (99) Other
[ ] (9) Group Home (Other than DCF Operated)	

School	**Grade:**	**Special Ed: Yes [ ] No [ ]**	**Section 504: Yes [ ] No [ ]**
DCF Social Worker:			**Phone:**
Parent(s)/Guardian(s) Name:			
Parent(s) Address:			
Phone: (Home)	**(Work)**	**(Cell)**	**(Other)**
Email Address:			
Is the biological parent the legal guardian? Yes [ ] No [ ]		**If no, who is?***	

Family Type (Please check applicable box):	
[ ] (5) Emancipated	[ ] (12) Adoptive Family Two Caregivers
[ ] (8) Biological Family Two Caregivers	[ ] (13) Adoptive Family One Caregivers
[ ] (9) Biological Family One Caregivers	[ ] (14) Relative and/or Guardian Care Two Caregivers
[ ] (10) Foster Family Two Caregivers	[ ] (15) Relative and/or Guardian Care One Caregivers
[ ] (11) Foster Family One Caregiver	[ ] (99) None of the above

Primary Language Parent (Please check applicable box):
[ ] (1) English [ ] (2) Spanish [ ] (3) Other European [ ] (4) Asian [ ] (5) African [ ] (98) Other [ ] (99) Unknown

Primary Language Child (Please check applicable box):
[ ] (1) English [ ] (2) Spanish [ ] (3) Other European [ ] (4) Asian [ ] (5) African [ ] (98) Other [ ] (99) Unknown

Please check all that apply:
Child lives with: Mother [ ] Father [ ] Other [ ] (Specify) _____

Other relevant family members/persons in household	Relationship	Age	School	Grade

Other Referral Concerns:

Clinical Diagnoses (if known):

Diagnosed by/Date:

Child previously referred to Systems of Care: [ ] Yes [ ] No **If yes, what collaborative or region:**

Service Providers – Current and Previous

Dates	Name	Agency	Number

Please note child's functional impairment/strengths in relation to: (Please check all applicable reasons for referral below)		
[ ] (1) Suicidal Ideation	[ ] (22) Witness of Physical Assault	[ ] (43) Sleep Disturbance/Sleep Disorder
[ ] (2) Suicidal Attempts/Gestures	[ ] (23) Victim of Physical Assault	[ ] (44) Severe Sibling Conflict
[ ] (3) Depressed	[ ] (24) Victim of Other Violent Crimes	[ ] (57) Police Contact
[ ] (4) Self-Mutilation	[ ] (25) Pregnancy of the Child	[ ] (58) Property Damage
[ ] (5) Other Self-Injurious Behavior	[ ] (26) High Risk Behavior (Dangerous Play, Promiscuity)	[ ] (59) Theft
[ ] (6) Suicide by Family Member	[ ] (27) Relocation of Family	[ ] (60) Threat to Life of Others
[ ] (7) Death or Loss of Significant Other	[ ] (28) Peer Relationship Problems	[ ] (61) Extreme Verbal Abuse
[ ] (8) School Phobia	[ ] (29) Physical Disability	[ ] (62) Cruelty to Animals
[ ] (9) Suspension from School	[ ] (30) Homicidal Ideation	[ ] (63) Social Contact Avoidance
[ ] (10) Being Expelled from School	[ ] (31) Homicidal Plan	[ ] (64) Over Dependence on Adults
[ ] (11) Running Away	[ ] (32) Physical Violence/Aggression by the Child	[ ] (65) Truancy
[ ] (12) Being Expelled from Home	[ ] (33) Oppositional Behavior	[ ] (66) Academic Problems
[ ] (13) Eating Disorder	[ ] (34) Sexual Offending by the Client	[ ] (68) Somatic Complaints
[ ] (14) Alcohol Abuse	[ ] (35) Sexual Abuse of the Client	[ ] (71) Bladder Difficulties
[ ] (15) Marijuana Abuse	[ ] (36) Fire-setting	[ ] (72) Non-Compliance
[ ] (16) Amphetamine Abuse	[ ] (37) Delinquent Activities	[ ] (73) Strange Behavior
[ ] (17) Other Substance Abuse	[ ] (38) Symptoms of Psychosis (delusions, thought disorder, etc)	[ ] (74) Hyperactive/Impulsive
[ ] (18) Significant Time Living Apart from Parents	[ ] (39) Severe Mental Illness not Specified Above	[ ] (75) Attentional Difficulties
[ ] (19) Severe Parent-Child Conflict	[ ] (40) Anxiety-Related Symptoms	[ ] (76) Poor Self-Esteem
[ ] (20) Witness of Domestic Violence	[ ] (41) Other problem not listed above	[ ] (77) Sexual Acting Out
[ ] (21) Witness of Homicide	[ ] (42) School Refusal	[ ] (93) Problematic Bowel Activity

Area	Strengths	Reasons for Referral (Please enter codes from previous page)	Examples/Description of Behaviors
Home & Family			
School			
Community			

Signature of parent/guardian is ***REQUIRED*** for processing

"I understand that my signature gives the referring agency permission to share the above information necessary for the referral with the Care Coordinator for the local System of Care Collaborative. I understand that this information will be used to determine eligibility for the Systems of Care."

Signature of Legal Guardian: _____

Date: _____

FAVOR, Inc. (www.favor-ct.org) is a statewide family advocacy organization, run by and for parents/guardians of children with mental health needs in Connecticut. They work collaboratively with local Community Collaboratives/Systems of Care to help families who are referred for Care Coordination. The FAVOR Family Advocacy program provides trained Family Advocates who can assist families through individual advocacy, including help in learning how to effectively advocate for their child in school, juvenile justice services or other family-identified priorities. The advocates assist families in participating at meetings, provide information/help in learning how to access resources, and linkage to parent-to-parent support.

I am not interested in FAVOR services at this time [ ]

I would like to receive additional information on FAVOR, Inc. [ ]

I would like my referral to be forwarded to FAVOR for Family Advocacy Services [ ]

Signature of Legal Guardian: _____

Date: _____